

Acute care in England: challenges and initiatives for improvement

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Plan

- Deinstitutionalisation in England: achievements
- Challenges still faced in 2013

Achievements (1) Asylum closures



Corridors at High Royds asylum, Yorkshire

109/127 asylums closed by 2013

TAPS study (Leff et al): planned discharge from 2 asylums of 670 patients, most to supported residential services. Few adverse outcomes.

Most people who would previously have been long stay asylum residents live uneventfully in community most of time, prefer to do so.

3 bedroom penthouse for sale

£2,500,000

Princess Park Manor Royal Drive



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Exterior



Princess Park Manor

Royal Drive, Friern Barnet, N11 3FL

1, 2, 3 and 4 bedroom apartments

A luxurious living link with the glory of Victorian England.

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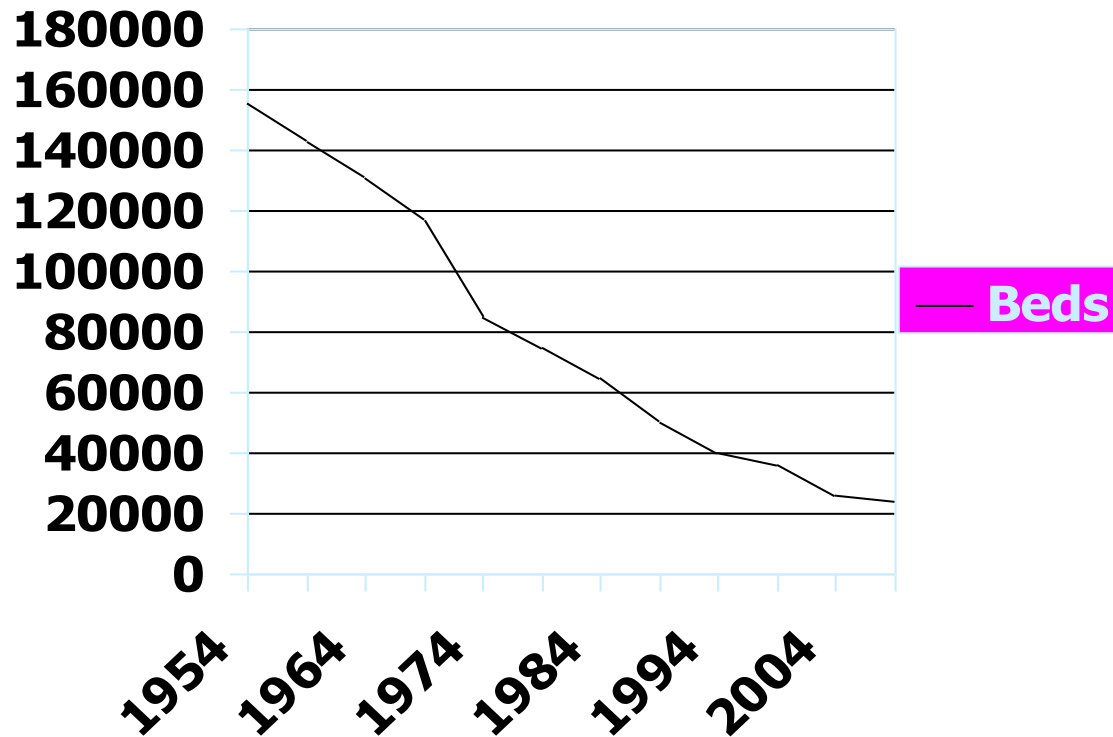
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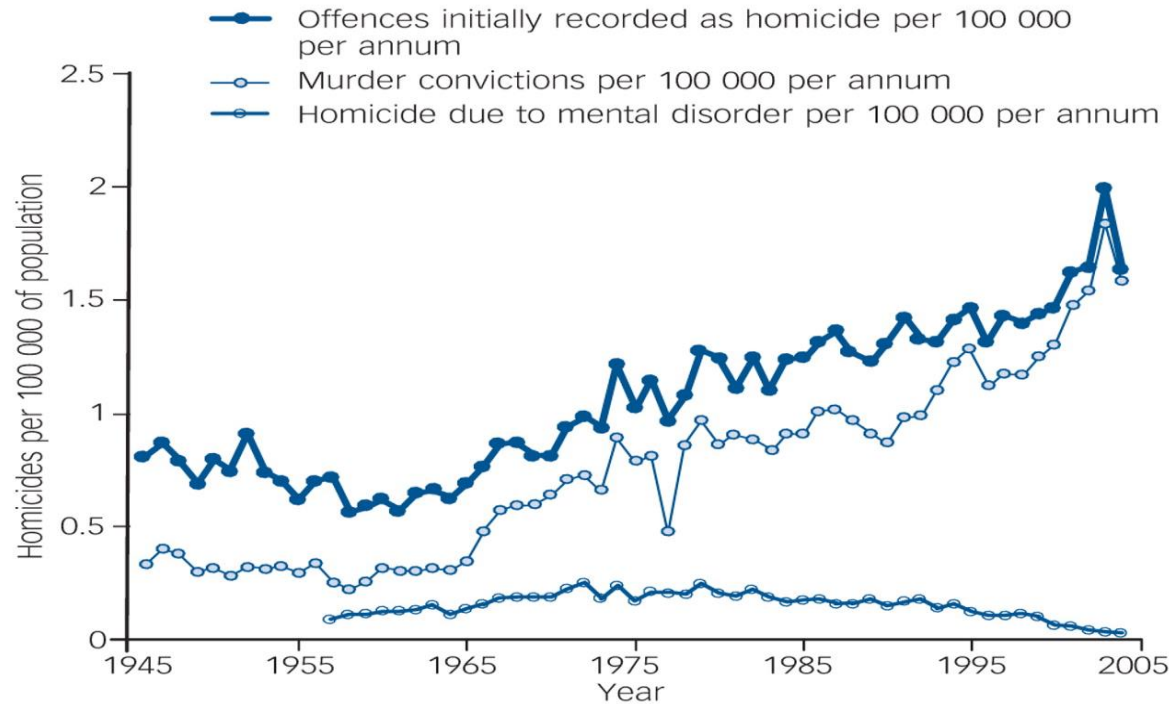


Achievements (2) Decline in overall bed numbers without danger to public



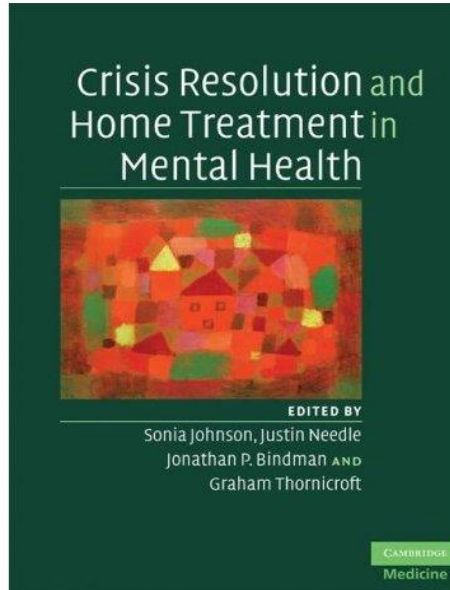
Accepted we can do without many long-stay beds, but concerns about reinstitutionalisation in secure units and supported accommodation of uncertain quality (Priebe).

Fig. 2 Homicide rates in England and Wales, 1946-2004.



Large, M. et al. *The British Journal of Psychiatry* 2008;193:130-133

Achievement 3 : Alternatives to admission in England



Crisis teams – 1930s-

24 hour multidisciplinary teams providing rapid assessment, home visits up to twice daily.

National policy in England 2001-2010.

Still available in most areas



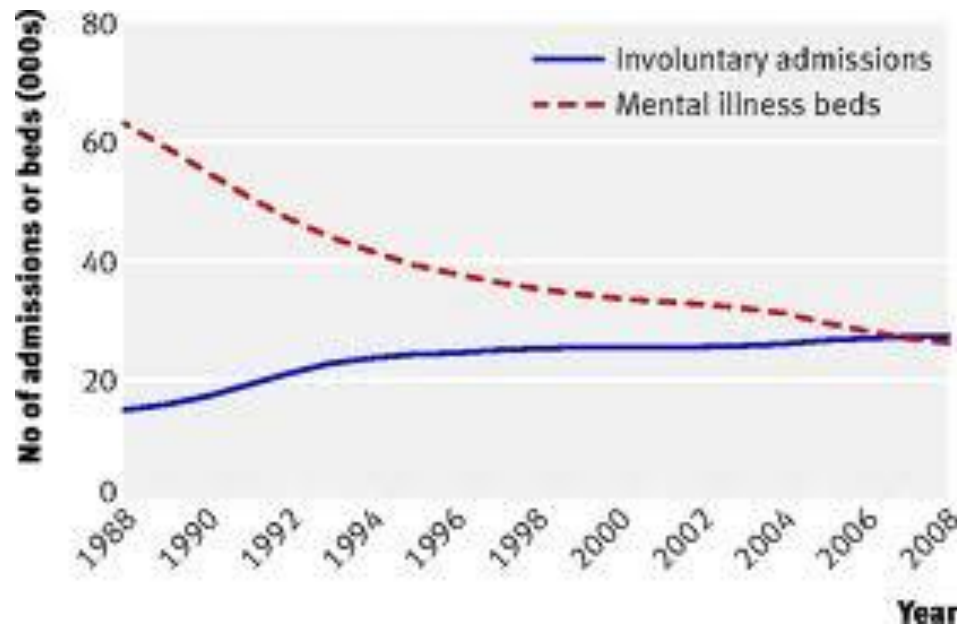
Drayton Park Women's Crisis House, Islington

Residential alternatives to hospital 1950s-

e.g. Crisis houses in community with 24 hour staff, short admissions

25% of English catchment areas have access.

Challenges in acute care(1) the rising tide of compulsory admissions



McKeown
et al. 2011

Steadily increasing rate of involuntary admission as bed numbers fall.

Still continuing.

Why are compulsory admissions rising?

- Evidence-based explanation not yet available.
- Similar rise in other countries at parallel deinstitutionalisation programmes (e.g. Netherlands)
- Potential contributors:
 - Reluctance to go to crowded and disturbed wards, alienation from mental health services.
 - Increase in social isolation and exclusion, substance misuse, other social difficulties
 - Larger pool of people with mental illness in community when long-stay wards close
 - Decline in deference

What can be done to turn the rising tide of compulsory admissions?

Unsuccessful so far:

Alternatives generally result in falls in voluntary rather than compulsory admissions.

Compulsory Treatment Orders (Burns et al, 2013) – no impact on patterns of admission

Crisis cards for advance planning (Thornicroft et al, 2013) – also without effect.

What can we do:

Better implementation?

Longer term CTOs?

More fundamental change in relationship with service users?

Challenges in acute care (2) Quality of care

Many people told us about poor, even traumatic mental health experiences. We should not, as a society, be leaving people with urgent mental health needs isolated, frightened and unsupported in impersonal hospital settings. We should not be traumatising those who use these services to such an extent that they would do anything not to return.”

MIND, 2011

Institutionalization and dependency; intense social contact exacerbating acute psychosis; the opportunities to learn inappropriate behaviours from other patients; injury from patient-patient aggression; paradoxical loneliness through separation from social networks; loss of community tenure; loss of job; welfare benefit problems; despair and depression from seeing damaged and acutely ill others; stigmatization in the community of origin; and the acquisition of drug taking or other substance use habits or contacts

Bowers – potential iatrogenesis in hospital

Problems with care on acute wards in England

Some positive experiences but many concerns:

- Unsafe for patients
- Limited therapeutic relationships
- Lack of clear and feasible therapeutic models
- Unpleasant physical environments
- Availability of alternatives results in concentration of relatively disturbed, uncooperative people on wards
- Often also intimidating for staff with high rates of assault on them – military attitude develops

The many initiatives for quality improvement in English inpatient wards

STAR WARDS



AIMS

PET

RELEASING

TIME TO

CARE



TIDAL MODEL

REBUILDING

Evidence on outcomes of quality improvement initiatives

- No substantial evaluation of many initiatives.
- The Alternatives Study (Johnson, Lloyd-Evans, Slade et al): no impact from the “Tidal model”
- PET (Protected engagement time) study (Nolan et al) – no effect on service user experience from protected engagement time.

Len Bowers – Safewards study



- Culmination of 6 years research on conflict and containment on inpatient wards
 - Cluster RCT comparing 2 interventions:
 - Experimental intervention
(organisational): clear mutual expectations, soft words, talk down, positive words, bad news mitigation, know each other, mutual help meeting, calm down methods, reassurance, discharge messages (n = 10) + handbook
 - Control intervention
(wellbeing): desk exercises, pedometer competitions, healthy snacks, diet assessment and feedback, health and exercise magazines, health promotion literature, linkages to local sports and exercise facilities
- Both groups: 15% fall in conflict, 24% increase in containment.**

Challenges in acute care (3) integration with physical healthcare



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Is locating acute wards in the general hospital an essential element in psychiatric reform? The UK experience

JONATHAN TOTMAN, FARHANA MANN, SONIA JOHNSON

Abstract. Locating psychiatric wards in general hospitals has long been seen in many countries as a key element in the reform of services to promote community integration of the mentally ill. In the

Why has England largely given up locating psychiatric wards in general hospitals?

Little discussed – current factors:

For general hospital

- Normalising
- Close link to physical health services
- Local

For freestanding units:

- Different Trusts/funders
- Disappointment with extent to which stigma challenged
- Has not resulted in closeness to physical health care – other initiatives in place.
- Space constraints often severe in general hospital, gardens unavailable.

Acute care in England, 2013

Some achievements

- Large nineteenth century asylums mostly closed
- Psychiatric bed numbers greatly reduced
- No consequent rise in homicide or suicide by mentally ill
- Network of alternatives to acute admission across the country

Some limitations:

- Great concern regarding the quality of care in hospitals
- Aspiration to bring together physical and mental health care in holistic general hospital units mostly abandoned
- Rising rate of compulsory admissions
- Variable success of alternatives

Challenges for UK acute psychiatry

- Making ward environments safe and acceptable to service users and staff
- Implementing initiatives for quality improvement that are evidence-based and feasible
- Enriching therapeutic relationships on wards – not achieved by increasing contact time alone
- Integration with physical healthcare, whether through co-location or other initiatives
- Maximising the effectiveness of alternatives

THANK YOU!

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Len Bowers – Safe Wards initiative

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